NHS England

NoECCN North of England Critical Care Network

NHS Critical Care Operational Delivery Networks England, Wales & Northern Ireland

NHS England North (Cumbria and North East)

North of England Critical Care Network:

Paediatric Critical Care Escalation Framework

V1

Revised 19 December 2017

Document Management

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Linked Plans:

- **North of England Critical Care Network *Adult Critical Care Escalation Framework* (ACCEF), December 2017**
- **North of England Critical Care Network *Ethical Framework for Utilisation of Critical Care in Response to Exceptional Demand*, September 2015**
- **North of England Critical Care Network *Guidelines for Escalation of Ebola Virus Disease,* September 2015**
- **NHS England North (Cumbria and North East), *Mass Casualty Framework* , August 2017**
- **NHS England North (Cumbria and North East), Public Health England North East Centre. *Pandemic Influenza Operational Plan*, July 2017 (***Does not cover Cumbria*)

Contents

This plan has been developed by the North of England Critical Care Network (NoECCN) which includes all the paediatric critical care units in the North East in NuTH and JCUH

The Network is accountable to NHS England through NHS England North (Cumbria and North East)

Purpose

The purpose of this framework is to co-ordinate an effective operational response across the North East and North Cumbria health economy to increased demand for Paediatric Critical Care. Expected triggers are:

1. Winter surge due to the rise in respiratory illness requiring critical care support. This is predictable and happens every winter to a greater or lesser extent.
2. Pandemic infection, for example influenza. This may impact significantly if coincides with winter surge.
3. Mass Casualty Incident. The initial response is described in regional and hospital major incident frameworks. Triggering of PCCEF will depend upon the number and type of paediatric casualties.

Application

NHS England's requirements as detailed within the relevant document[1] will be met by adoption of this framework by acute trusts, alongside the on-going review of internal trust plans for surge capacity within paediatric critical care.

Structure

- Key enabling measures are highlighted in section 2.

- The key response section of the plan is section 5 which outlines escalation levels, triggers for further escalation and mitigating actions.

Activation

- This plan will be activated in response to the triggers and levels identified in section 5.4.

- Paediatric Critical Care will describe local pressure levels linked to ccOPELp (**c**ritical **c**are **O**perational **P**ressure **E**scalation **L**evel **p**aediatrics) identified in section 5.4, and integrate this with individual trust surge/Major Incident Plans (MIPs).

- ccOPELp 1 is the default position for each of the Paediatric Critical Care Units of the region.

- Each paediatric critical care unit (PCCU) can independently trigger escalation to ccOPELp 2. This will activate the 'daily phone call' protocol and the Paediatric Network Lead or nominee will be informed.

- Two PCCUs declaring ccOPELp 2 will activate the Network Paediatric Critical Care Control Group (NPCC-CG).

- Escalation to Network ccOPELp 3 is a decision that can only be triggered by the NPCC-CG. The NHS England Cumbria and North East and NHS England North 'On-call' Directors will be informed in a timely manner.

[1] **Paediatric Intensive Care Surge Standing Operative Procedures** (NHS England Specialised Commissioning December 2016)

- Escalation to Network ccOPELp 4 will in itself trigger the establishment of NHS strategic command, if this has not already been established in response to the underlying pressures/acute incident. This will usually be led by NHS England North based on clinical advice from the NPCC-CG.

Further escalation actions will be determined by NHS Command and Control structures

De-escalation decisions are made by the group responsible at the higher level, for example at ccOPELp 3 the NPCC-CG would determine de-escalation to ccOPELp 2. This will be based on clinical advice.

Section 1: Background

The first iteration of this framework was developed in response to the influenza pandemic in 2009. The revised framework (plan) was implemented in response to the pressures on Paediatric Critical Care capacity due to influenza A (H1N1) 2009 in winter 2010/11.

The North East Paediatric Critical Care Escalation Plan (PCCEP) was developed in tandem with the *North East Adult Critical Care Escalation Plan* (ACCEP) to ensure compatibility. Both the PCCEP and ACCEP are underpinned by the revised *Ethical framework for utilisation of critical care in response to exceptional demand.* These were all published as working documents by mid December 2010 to support response to the emerging pressures on critical care. The final V1.0 plan incorporated the lessons learned, in particular from the formal debrief meeting on 8 March 2011. Further major revision V 2.0 was required in March 2013 and V 3.0 in January 2014 in response to changes in NHS structures. The plan was revised further, V4.0 to incorporate lessons learnt from exercise 'Mother Goose' which was tested on the May 8th 2014. Minor revisions were made in December 2016 to include the North East Children's Transfer and Retrieval (NECTAR) service, V4.1. The plan was tested in exercises Michelle, Stonehart and Border Reiver in 2017. This plan has now been further revised to incorporate the national pressure descriptions 'Operational Pressures Escalation Levels Framework' (OPEL)[2] and will be referred to as the *Paediatric Critical Care Escalation Framework* (PCCEF) V1.0.

Section 2: Enabling measures – actions required

During the pandemic of influenza A (H1N1) in 2009, a number of enabling measures were put in place to deliver the required increase in paediatric critical care capacity. Some of these were fully implemented but others were not once the lower than expected impact of the second wave became apparent.

In order to maintain surge capacity these enablers will need to be maintained, held on standby or retained as procedures to be reactivated.

[2] Operational Pressures Escalation Levels Framework (NHS England, 2016)

Actions for the critical care network and for trusts in relation to internal plans for surge capacity/major incidents are highlighted in this section.

2.1Enabling measures

- Extra bed spaces
  - Ability to expand 'within walls' at GNCH.
  - Ability to expand into theatre areas GNCH and JCUH.
  - Agreement to accommodate children on adult intensive care units as described in Section 5.

- Staffing
  - Identification of staff who could be trained/retrained to work in PCC
  - A 'clinical team' management model.

- Equipment
  - Extra bed spaces fully equipped.

- NECTAR children's transport service. Single point of contact for the region (telephone number 0191 282 6699)
  - For advice
  - For a PCC bed
  - For transport

- NECTAR documents all contacts and keeps a record of decisions and outcomes. NECTAR will keep a list of all children requiring PCC but not in a PCC, and will maintain daily contact and be available to give advice.

- Terms of Reference for the Network Paediatric Critical Care Control Group (NPCC-CG) which includes senior clinical representation from the Great North Children's Hospital PCCU, Freeman PCCU James Cook University Hospital PCCU and NECTAR. This will be facilitated using teleconferencing via NECTAR.

Section 3: Principles underpinning the escalation framework

3.1 Organisational principles

- That supporting the delivery of paediatric critical care is a shared responsibility of **all** NHS organisations (excluding mental health trusts) in the North East and North Cumbria.

- That paediatric critical care (PCC) capacity will double their Level 3 capacity (and maintain for 96 hours[3]) in event of mass casualty involving children.

[3] Concept of Operations for Managing Mass Casualties (NHS England, 2017)

- That for incidents which impact (or are likely to impact) on PCC capacity across the network at ccOPELp 3 and above, NHS England North (Cumbria and North East) or NHS England North will command the critical care response as described in section 5

- Specialised commissioning as commissioners of PCC will be informed by NHS England North (Cumbria and North East) at ccOPELp 3

3.2 Clinical principles

- That PCC will be delivered to national clinical standards until fully staffed capacity is exceeded.

- That an escalation framework will be implemented to deliver PCC to children able to benefit which will balance increased capacity with the minimum possible reduction in standards of care.

- That as far as possible all children who require ventilation for more than 24 hours will be cared for within the current designated paediatric intensive care units.

- That all children under five years of age requiring PCC will be cared for within the current designated paediatric intensive care units until ccOPELp 4 is reached (see section 5.4).

- That all clinical decisions will be underpinned by the *Ethical framework for utilisation of critical care in response to exceptional demand,* which is published alongside the two critical care escalation frameworks.

Section 4: Current commissioned PCC capacity (November 2017)

Table 4.1: Current commissioned PCC capacity

Location of PCCU	Trust	Commissioned L 3 beds	Commissioned L 2/1 beds	Comments
GNCH, Royal Victoria Infirmary	NuTH	11	2 (NuTH commissioned)	Physical capacity18 beds – can be staffed for short periods 5 cubicles Isolation bay
Freeman	NuTH	11		Specialised Cardiothoracic Supra-regional ECMO and heart failure
James Cook University Hospital	STH	4	2	1 cubicle
Total		**26**	**4**	

GNCH

PCCU at the RVI site is the regional general critical care unit which also supports paediatric surgery including renal transplant, all paediatric medical subspecialties, neurosurgery, trauma and orthopaedics, ENT, specialist oncology and bone marrow transplant work.

FRH

PCCU at the FRH site is the specialist cardiothoracic unit including transplant surgery, and is a supra-regional ECMO and heart failure facility.

JCUH

PCCU at JCUH provides single organ support for a range of medical and surgical services.

NECTAR children's transport service

NECTAR is the single point of contact for advice, locating a PCC bed and transport.

NECTAR has two commissioned teams:

- Team 1 – operational 24/7

  - Transfer of critically ill children for paediatric intensive care support with a team consisting of a doctor, nurse and ambulance driver.

- Team 2 – operational daytime 7days/week
  - Transfer of children back to their local hospital for step-down care. The transfers are nurse led with an ambulance driver.

- NECTAR collects data about the regional general paediatric beds and paediatric critical beds available in the North East and the neighbouring regions. This overview helps co-ordinate patient flow during an escalation.

- NECTAR will use teleconferencing facilities to host the Network Paediatric Critical Care Control Group (NPCC-CCG) when activated.

Surge capacity

- Surge capacity would be implemented as part of the agreed actions at specified escalation ccOPELp levels as described in section 5.4.

- PCCU at the GNCH can expand capacity from 11+2 beds to 18 L3 beds. In addition in the event of extreme demand which involved the cancellation of elective surgery, the adjacent paediatric recovery could accommodate up to 6 ventilated beds.

- Plans are in place at James Cook University Hospital to provide additional critical care spaces using theatre and adjacent areas.

Section 5: Escalation: triggers, levels and actions

5.1 Assumptions

- That all clinical decisions will be underpinned by the *Ethical framework for utilisation of critical care in response to exceptional demand.*

- The ccOPELp levels are defined in relation to a rapidly progressive increase in demand for PCC. The most likely scenario would be an outbreak of a serious communicable disease such as a pandemic influenza virus of greater severity than pandemic Influenza A (H1N1) 2009.

- The responses assume that there is similar pressure across the country.

- However, an acute incident (such as major accident or chemical poisoning involving many children) may require a short term response at a high ccOPELp level. In most acute scenarios it is likely that children can be stabilised and relatively quickly transferred to other regions.

- The ccOPELp actions relate to a situation where there is excessive demand for PCC but not for adult critical care. Where there is also excessive demand for adult critical care, actions will have to be modified. This is likely to cause more rapid escalation to a higher ccOPELp level.

5.2 Network escalation / de-escalation decisions

- This Network framework will be activated in response to the triggers and levels identified in section 5.4.

- Escalation to Network ccOPELp 2 is an internal decision made by the Paediatric Intensive Care lead consultant at the Great North Children's Hospital PIC unit, Newcastle in discussion with colleagues at Freeman PCC and James Cook. Two PCCUs declaring ccOPELp 2 will activate the Network Paediatric Critical Care Control Group (NPCC-CG). The North of England Critical Care Network will be informed in a timely manner.

- Escalation to Network ccOPELp 3 is a decision that can only be triggered by the NPCC-CG. The NHS England Cumbria and North East and NHS England North 'On-call' Directors will be informed in a timely manner. If NHS England North (Cumbria and North East) strategic command is already established, escalation will be a strategic command decision.

- Escalation to Network ccOPELp level 4 will in itself trigger the establishment of NHS strategic command, if it has not already been established in response to the underlying pressures/acute incident. This will usually be led by NHS England North based on clinical advice from the NPCC-CG.

- Further escalation will be determined by the NHS strategic Command structure.

- De-escalation decisions are made by the group responsible at the higher level, for example at ccOPELp 3 the NPCC-CG would determine de-escalation to ccOPELp 2.This will be based on clinical advice.

5.3 Role of the Network Paediatric Critical Care Control Group

- There will be 'Terms of Reference' (Appendix 2) for the Network Paediatric Critical Care Control Group (NPCC-CCG) which includes senior clinical representation from the GNCH PCCU, Freeman PCCU James Cook PCCU and NECTAR (usually by teleconference) in relation to PCC issues.

- At specified escalation levels (usually ccOPELp 3 and above), in relation to PCC across the Network NPCC-CCG clinicians on the call will:

    - Make decisions on escalation and de-escalation in keeping with this framework
    - Report daily or more frequently as required through the NPCC-CCG to NHS England North

- Make decisions in relation to admission and discharge criteria in keeping with this framework
- Support clinicians in making individual case decisions
- Monitor cases being managed outside of the PCC units and maintain a 'line list'

5.4 Network ccOPELp triggers, levels and actions

Network ccOPELp 1 (default position)

Current position and response to "expected" pressures. PCCUs functioning normally with usual bed pressures assisted by:

- Monitoring of all PCC capacity by NECTAR
- Continual attention to patient flow and prompt step down to ward based care
- Movement of children between units according to their needs
- Staff all commissioned bed capacity which may require:
  - Requests to nursing staff for overtime
  - Moving nursing staff between units to optimise staffed capacity

Network ccOPELp 2

Trigger

When **any** PCCU reaches staffed capacity ccOPEL 2 is triggered.

Actions (in addition to those at ccOPELp 1)

- Inform Paediatric Network Lead or nominee
- Daily phone call between PCCUs (Appendix 3) to establish:
  - Current bed state
  - Staffing this shift and next 24 hours
  - Activity expected in the next 24 hours
    - Admissions
    - Elective surgery?
    - Discharges
    - 'patient progress' e.g. extubations imminent
  - Establish NECTAR capability over next 24 hours

Purpose

- Facilitate maximising staffed capacity across the network
- Identify and prioritise urgent surgery, postpone elective surgery
- Move patients to optimise capacity

At ccOPELp 2 the following may occur:

- Elective surgery is postponed
- No out of region referrals accepted unless for specialist care
- Children are transferred out of region if a suitable bed is not available

NB: At ccOPELp 2 PCCU at GNCH can operate over its' commissioned capacity of 11+2 beds by admitting children into the 'within walls' surge capacity for short periods, up to 14 level 3 beds, without triggering ccOPELp 3. This is a clinical decision based on patient flow.

NHS England North (Cumbria and North East) recognises the region is operating over capacity.

Network ccOPELp 3

Triggers

When at least 2 PCCUs declare ccOPEL 2
OR
When 1 PCCU declares ccOPEL 2 and neighbouring regions are at OPEL 2 or above, so that children are not able to transfer out of region.

Actions (in addition to those at ccOPELp 1 and 2)

All elective surgery requiring a critical care bed is postponed

Activation of the NPCC-CG which meets twice daily (via teleconference): Tasks include:

- Inform and involve hospital management teams
- Facilitate clinical teams with patient flow ensuring prompt step-down of patients to ward based care
- Review cases requiring urgent surgery across Network and assist clinical teams to prioritise equitably
- Liaise with hospital management teams to review elective surgery requiring an inpatient bed and consider progressive postponement to create capacity in the hospital at large
- Reports daily or more frequently to NHS England North or to NHS Strategic command if established

Children >12years without significant co-morbidities can be admitted to adult intensive care areas (individual case discussion with NECTAR clinician)

- On-going clinical support will be available from the NECTAR clinician – minimum daily contact expected
- Transfer to a PCCU will occur as soon as possible, prioritising the youngest and sickest or those needing specialist input

- Progressively open additional paediatric critical care beds available 'within walls' at GNCH (maximum 6 extra Level 3 beds). Requires:

- Nursing staff
    - Requests to nursing staff across the network for overtime
    - Moving nursing staff between units to optimise staffed capacity
    - Using ward based nursing staff (capacity created by postponing surgery) to work with critical care nursing staff
- Medical staff
    - Ensure fully staffed rota
    - May request assistance from paediatric directorate
- Equipment/Disposables
    - Continuous improvement programme to ensure 18 fully equipped bed spaces

Transfers from out of region for tertiary or quaternary services may no longer be able to be accepted.

Network ccOPELp 4

Trigger

Despite measures above, children requiring critical care exceed the beds available.

Actions (in addition to those at ccOPELp L1, 2 and 3)

NPCC-CG meets twice daily via teleconference

NPCC-CG will report to agreed timescales to NHS strategic command
.
All previous escalation actions will be in place. The following to be implemented progressively as pressure increases:

- All paediatric elective surgery is postponed
- All leave for critical care staff cancelled
- Younger children without significant co-morbidities can be admitted to adult intensive care areas after individual case discussion with NECTAR clinician.
    - Ideally at the RVI or JCUH to allow closer collaboration with PCC staff, and may involve transfer of adult patients to other units
    - Otherwise, ongoing clinical support available from NECTAR clinician – minimum daily contact expected
    - Transfer to a PCCU will occur as soon as possible, prioritising the youngest and sickest, or those needing specialist input
- Progressively open emergency critical care bed capacity in theatre/recovery areas at GNCH and JCUH.
    - Medical and nursing staff from anaesthesia and recovery to provide support to trained PCC staff (as elective surgery progressively cancelled)
    - Move to ‘clinical team’ management model with PCC trained nurses supervising anaesthetic and recovery staff in small teams.

At ccOPEL 4 it will not be possible to maintain the staff: patient ratios as set in PIC standards.

At ccOPEL 4 NPCC-CG will refer to the document ‘Ethical framework for utilisation of critical care response to exceptional demand’ to inform clinical decision making in terms of admissions to critical care, treatment limitation and withdrawal of intensive care.

All subsequent action will be determined by NHS command and control structures

Appendix 1

Network Medical PCCU Leads

Paediatric Critical Care		
Sue Jackson	GNCH PICU RVI	Newcastle Hospitals NHS FT
Yam Thiru	Freeman Hospital PCICU	Newcastle Hospitals NHS FT
Jonathan Grimbley	James Cook University Hospital PCCU	South Tees NHS FT
Aravind Kashyap	North East Children's transport and retrieval NECTAR	Newcastle Hospitals NHS FT

NoECCN Personnel Contacts

Table of NoECCN Personnel Contacts		
	'Normal Hours' 8.00-17.00 Monday to Friday	**'Out of Hours' 17.00-08.00 (Monday-Friday) Weekends**
North East & Cumbria Locality	Lesley Durham (Director) **07824 498625** Dave Cressey (Medical Lead) **07941 167155** Jan Malone (Administrator) **07827 978559**	Consultant Intensivist on call (RVI – Ward 18 Neuro-Trauma ICU) **0191 2821788**
Tees Valley & South Durham Locality	Julie Platten (Manager) **07881 832184** Isabel Gonzalez (Medical Lead) **07977 153036** Sarah Gray (Administrator) **07765 253098**	Consultant Intensivist on Call (JCUH – GICU) **01642 282680**
Paediatric Critical Care Leads	Susan Jackson (Paediatric Medical Lead) **07771 930315**	Consultant Paediatric Intensivist on call GNCH PCCU (RVI Newcastle) **0191 282 6012**
	Lynda Pittilla (Paediatric Nurse Lead) **07791 041915**	Consultant Paediatric Intensivist on call JCUH PCCU **01642 854 667**
North East Children's Transfer and Retrieval (NECTAR) Phone number – 0191 2826699		

Appendix 2:

NETWORK PAEDIATRIC CRITICAL CARE CONTROL GROUP (NPCC- CC)

Terms of Reference and Membership

Purpose
The Network Paediatric Critical Care Control Group (NPCC-CG) will be the command group for PCC across the north east once the relevant alert level is reached. Its purpose is to coordinate, monitor, and direct a region wide (North East and North Cumbria) response to an exceptional demand for paediatric critical care.

[Depending on the cause of the pressure on PCC, both the Trust and Network (adult) Critical Care Control Groups (CCCGs) may also be coordinating the adult critical care response. Mechanisms for coordinated communications must be established between these groups]

Broad Remit of the Group

- To monitor and coordinate paediatric critical care patients, staffing (nursing, medical, and admin), disposables and equipment for critical care services across the network.
- To assess critical care demands and advise the Hospital Tactical Control Teams on the appropriate reallocation of staff, beds, equipment, disposables and drugs
- To monitor admissions, access and throughput to critical care beds and direct the appropriate expansion and cohorting across the NoECCN organisations
- To advise the Trust / Network on any changes to normal critical care standards of care e.g. equipment and staffing
- To prioritise and direct the delivery of staff education and training to support the staffing requirements of critical care.
- To coordinate staffing rotas/off-duty and support the Hospital Tactical Control Team with organisation and coordination of critical care services throughout the Trust.
- To ensure the use of the regional '*Ethical framework for utilisation of critical care in response to exceptional demand'* this underpins all decisions at all times. (A multi-professional team with no less than two consultants will decide on the admission and access to critical care beds and limitation on treatment. When appropriate withdrawals of treatment will be discussed at the daily meeting and will be recorded in meeting notes)
- To maintain and review a log of ethical decisions
- To review all patients on the 'line list'
- To perform a stringent review of all elective surgery requiring PCC, with a view to cancellation of surgery in accordance with the Trusts' Major Incident Plan and the Network ccOPELp level
- Facilitate early/appropriate discharge to ward areas where clinically feasible.

- To interact with and inform as required NHS England North

Timing and Operation

- The Network Paediatric Critical Care Control Group (NPCC-CG) will be convened in line with the Network PCCEF and Newcastle Trusts' Major Incident Plan.
- A Chair will be identified who will have responsibility for the actions of the NPCC-CG. This would ideally be the duty PICU Consultant at the GNCH (RVI) or a designated deputy'
- The establishment of NPCC-CG may be at short notice and will be driver dependent
- The group will meet daily / weekly or as required dependent upon on activity and driver to coordinate critical care activities
- The chair of the group will report to the Trust Hospital Control Team and NHS England North
- A teleconference facility will be provided for staff to dial in from their units. The dial in number is **0191 2826699**
- The conference call will be recorded and key decisions documented

Membership

- The NPCC-CG will be multi-professional
- Senior clinical representation from the Great North Children's Hospital PICU, Freeman PICU and James Cook PCC team and NECTAR, and will include a Consultant Paediatric Intensivist and at least one other Paediatric Medical Consultant.
- A member of the NoECCN Team (in office hours)
- Senior PCC Nursing staff and AHP's as appropriate
- Senior Pharmacist
- Senior Trust Manager / Emergency Planning Officer
- Senior Bed Manager
- *Others as appropriate such as outreach for early discharge planning situations*
- Ad hoc partners as appropriate

Governance

The NPCC-CG will be accountable to the Newcastle Trust Tactical Command and NHS England North at ccOPELp 3 and above.

Administration and Coordination

Secretariat to NPCC-CG will be provided by a member of the NECTAR / Critical Care / Anaesthetic admin team or an appropriate person as designated by the chair of the group.

ccOPELp 2 Daily Phone Call – SitRep 16:00 teleconference

Conferencing Phone Number: **0800 032 8069** Participant Passcode: **98583916 then #** **(NECTAR chair 20937839 then #)**

Location Beds	Current occupancy Level 3	Current occupancy Level 2/1	Current Capacity	Expected discharges next 24hrs	Patient progress next 24hrs e.g. imminent extubations	Expected admissions next 24hrs Specify: • emergency • urgent surgery • elective surgery	Staffing Fully staffed? (=commissioned beds open)	Review staffing • Move staff between units • Request overtime • Assistance from adult intensive care
GNCH 11+2								
JCUH 4+2								
FRH 11								
NECTAR capability next 24 hrs								

Outcome – Priority list of admissions/cases

1. Capacity for expected activity in next 24hrs – surgical cases can be listed. Unexpected overnight admissions prompt cross-site discussion in the morning if needed.
2. Definitely short of capacity for expected activity in next 24hrs – postpone all elective cases and expedite finding staff for urgent cases. Inform directorate teams.
3. Possibly/probably short of capacity for expected activity in next 24hrs – list 1 surgical case (based on priority) and review situation with cross-site discussion in the morning.